DEPARTMENT OF HUMAN SERVICES

FATALITY REVIEW EXECUTIVE SUMMARY

FY 2012

Compiled by
Department of Human Services
Office of Services Review
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JULY 1, 2011 – JUNE 30, 2012

INTRODUCTION

Department of Human Services (DHS) Fatality Review Policy requires a review of the deaths of all individuals for whom there is an open DHS case at the time of death or in cases where the individuals or their families have received services through DHS within 12 months preceding the death. Information obtained from case reviews provides insight into systemic strengths and highlights areas in which changes or modifications could enhance systemic response to client needs.

During FY 2012, 177 deaths of current or past DHS clients were reported to the Office of Services Review (OSR). There were four suicide deaths (2%) and five homicides (3%). The reviews indicate that abuse and/or neglect were contributing factors in nine (5%) of the 177 deaths. Six (14%) of the 42 child fatalities reported by the Division of Child and Family Services (DCFS) died as the direct result of abuse or neglect by their parents/caretakers. The deaths of three (5%) of 63 DSPD fatalities could be linked to incidents of neglect/abuse.

Of the 42 fatalities reported by DCFS, 30 reviews were held (71%), 12 reviews were waived (28%), with no reviews pending. Forty-one of the 63 reported DSPD fatalities were reviewed (65%), 22 reviews were waived (35%), with no reviews pending. One Division of Juvenile Justice Services (DJJS) fatality was reviewed (100%). On-site reviews were held for two (67%) of the three reported Utah State Developmental Center (USDC) fatalities with one review pending (33%). Utah State Hospital (USH) conducted an on-site review for its one reported fatality (100%).

The deaths of 54 individuals who received services through the Division of Aging and Adult Services (DAAS) were reported, with all formal reviews (100%) being waived. The Office of the Public Guardian (OPG) reported the deaths of 14 individuals for whom they provided services. One of these individuals (7%) was also receiving services through DSPD at the time of death, and a full committee review was held for that individual. Full committee reviews were waived for 13 individuals (93%) receiving services solely through OPG. OPG provided the Fatality Review Coordinator with comprehensive written reports detailing services provided and information relating to the deaths of their 14 clients (100%).

There were 97 (55%) reported deaths of male clients and 80 (45%) reported deaths of female clients. Reported deaths included 19 infants (11%) under the age of one year; 27 individuals (15%) between the ages of one to 19 years; 39 individuals (22%) between the ages of 20 to 49 years; 41 individuals (23%) between the ages of 50 to 69 years; 39 individuals ((22%) between the ages of 70 to 89 years, and 12 individuals (7%) between the ages of 90 to 100 years.

Included in the 177 reported fatalities were three (2%) Native Americans, two (1%) Asians, three (2%) Black/African Americans, 151 (85%) Caucasians, 16 (9%) Hispanics, and two (1%) Pacific Islanders.

During FY 2012, DCFS, in conjunction with the Office of the Attorney General, modified the definition of "physical abuse" to match statute. The new definition contained in the January 1, 2012, Practice Guideline release includes "harm or threatened harm". Workers have been provided with information on the concept of "threatened harm" and with guidance in supporting allegations of physical abuse when there are no visible marks or when harm is threatened but has not actually occurred.

In response to training recommendations made by the Child Fatality Review committee, DCFS administration included training reminders in its quarterly Mandatory Information Communication (MIC) on the following Child Protective Services (CPS) subjects:

- Using translation services to conduct accurate casework rather than using children as translators;

- Paying close attention to injuries on non-verbal children and being more assertive with the medical community in requesting additional medical tests, assessments and scans, including skeletal surveys, when it is felt they are necessary to ensure the health, safety, and well-being of a child/client;

- Reviewing a family's entire DCFS history, including unaccepted and unsupported cases;

- Ensuring that all information relevant to a CPS case is documented in SAFE prior to case closure as required in Practice Guideline 204.15.

DCFS training teams throughout the state have developed and presented the following trainings to program managers, supervisors, and caseworkers:

- Training on case closures;

- Training on injuries of non-mobile/non-verbal infants. The training team is also mentoring/training caseworkers on being more assertive with the medical community when they feel testing, assessments, scans, etc., are warranted;

- Training from Primary Children's Medical Center Safe and Healthy Families on accessing immediate medical attention if bruising is present, especially on an infant, and on identifying an appropriate response to serious physical injuries;

- New staff training on the importance of and need for workers to review a family's entire DCFS history, including unaccepted and unsupported cases, in order to gain a more complete understanding of the family's strengths and needs;

- Training on using a contracted interpreting service or a certified worker in every case where English is not the parent's primary language.

The DCFS Child Protection Program Administrator is attempting to identify necessary system infrastructure to establish a "trigger" to alert workers to the need for an in-depth review of cases that have DCFS histories and chronic patterns of DCFS involvement.

The DSPD Fatality Review Committee referred one case to the DSPD Quality Assurance team with concerns about a violation of Division policy and contract regarding the conveyance of medical Power of Attorney to two members of an individual's provider staff. Although the Quality Assurance team found no reason to believe that any criminal or nefarious motives existed for the arrangement, they referred the matter to the Bureau of Internal Review and Audit (BIRA) for further investigation. BIRA investigators concluded that although provider staff had violated Division policy and contract, there had been no financial fraud or exploitation on their part.

DEPARTMENT OF HUMAN SERVICES
EXECUTIVE SUMMARY
FY 2012

SUMMARY

DEPARTMENT/DIVISION	Number of Reported Deaths	Cases Open at Time of Death	Committee Reviews Held	Committee Reviews Waived	Reviews Pending	Male	Female
DEPARTMENT OF HUMAN SERVICES	**177**	**145**	**74**	**101**	**2**	**97**	**80**
DAAS *(Division of Aging and Adult Services)*	54	49	0	54	0	24	30
DCFS *(Division of Child and Family Services)*	42	17	30	12	0	26	16
DJJS *(Division of Juvenile Justice Services)*	1	0	1	0	0	1	0
DSPD – COMMUNITIY PLACEMENT *(Division of Services for People with Disabilities)*	59	59	37	22	0	36	23
DSPD/DAAS (Division of Services for People with Disabilities/Division of Adult and Aging Services)	2	2	2	0	0	2	0
DSPD/DCFS (Division of Services for People with Disabilities/Division of Child and Family Services)	1	1	1	0	0	1	0
DSPD/OPG (Office of the Public Guardian/Division of Services for People with Disabilities	1	1	1	0	0	0	1
OPG *(Office of the Public Guardian)*	13	13	0	13	0	5	8
USDC (*Utah State Developmental Center)*	3	2	1	0	2	1	2
USH/DSA/MH (*Utah State Hospital/(Division of Substance Abuse/Mental Health)*	1	1	1	0	0	1	0

CHART I
FIVE-YEAR COMPARISON
FY 2008 – FY 2012

	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012
DHS Reported Deaths	**171**	**130**	**159**	**164**	**177**
DAAS	**3**	**2**	**34**	**36**	**54**
DCFS	**59**	**49**	**38**	**53**	**42**
DCFS/DSPD	**1**	**3**	**2**	**0**	**1**
DJJS	**2**	**3**	**1**	**1**	**1**
DJJS/DCFS	**2**	**4**	**3**	**1**	**0**
DSPD	**75**	**49**	**61**	**46**	**59**
DSPD/DAAS					**2**
DSPD/OPG				**5**	**1**
OPG	**13**	**7**	**9**	**12**	**13**
USDC	**4**	**7**	**4**	**3**	**3**
USDC/OPG	**2**	**2**	**3**	**6**	**0**
USH	**10**	**4**	**4**	**1**	**1**
Cases Open at Time of Death	**124**	**106**	**111**	**121**	**155**
Cases Reviewed	**139**	**121**	**70**	**69**	**74**
Abuse & Neglect Deaths	**22**	**4**	**2**	**9**	**9**
Accidental Deaths	**10**	**12**	**18**	**24**	**14**
Homicides	**14**	**5**	**1**	**7**	**5**
Motor Vehicle or Auto/Pedestrian Accidents	**9**	**1**	**6**	**9**	**3**
Suicides	**5**	**7**	**10**	**8**	**4**
Could Not Be Determined	**10**	**9**	**6**	**3**	**9**

CHART II
AGE AT TIME OF DEATH
FY 2012

AGE IN YEARS	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/ OPG	OPG	USDC	USH
< 1	19		19								
1 – 3	4		4								
4 - 6	3		3								
7 - 10	0										
11 - 14	6		4		1		1				
15 - 19	14		12	1	1						
20 - 29	9				8						1
30 - 39	13	2			10					1	
40 - 49	17	2			13	1			1		
50 - 59	20	3			14	1			1	1	
60 - 69	21	11			7			1	2		
70 - 79	13	8			2				2	1	
80 - 89	26	17			3				6		
90 – 100	12	11							1		
TOTALS	177	54	42	1	59	2	1	1	13	3	1

CHART III
ACCIDENTAL DEATHS
FY 2012

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Asphyxia	2			
Choking		Male	30	DSPD
Positional		Male	3 weeks	DCFS
Auto/Pedestrian Accident	2			
		Male	2	DCFS
		Female	6	DCFS
Drug Toxicity	4			
		Male	`8	DCFS
		Female	16	DCFS
		Female	17	DCFS
		Male	44	DSPD
Drowning	1			
		Male	19	DJJS
Electrocution	1			
		Male	12	DCFS
Fall	1			
		Female	89	DAAS
Hypothermia	1			
		Male	26	USH
Motor Vehicle Accident	2			
		Male	13	DCFS
		Female	15	DCFS
TOTAL	14			

CHART IV
HOMICIDE DEATHS
FY 2012

MANNER OF HOMICIDE	DHS	GENDER	AGE	DIVISION
Gunshot	1			
		Male	15	DCFS
Blunt Force Injuries (Inflicted)	4			
		Female	2 months	DCFS
		Female	4.5 months	DCFS
		Male	5 months	DCFS
		Female	15	DCFS
TOTAL	5			

CHART V
SUICIDE DEATHS
FY 2012

MANNER OF SUICIDE	DHS	GENDER	AGE	DIVISION
Asphyxia (Hanging)	2			
		Female	16	DCFS
		Male	18	DCFS
Drug Toxicity	1			
		Female	18	DCFS
Gunshot Wound	1			
		Male	18	DCFS
TOTAL	4			

CHART VI
ABUSE/NEGLECT DEATHS
FY 2012

CAUSE OF DEATH	DHS	GENDER	AGE	DIVISION
Drug Exposure (in utero)	2			
		Male	1 hour	DCFS
		Female	6	DCFS
Fall from Wheelchair	1			
		Male	55	DSPD
Physical Abuse	4			
		Female	2 months	DCFS
		Female	4.5 months	DCFS
		Male	5 months	DCFS
		Female	15	DCFS
Sepsis due to Burns				
	1	Male	33	DSPD
Water Intoxication	1			
		Male	52	DSPD
TOTAL	9			

CHART VII
MEDICAL EXAMINER'S DETERMINATION
MANNER OF DEATH
FY 2012

MANNER OF DEATH	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/ OPG	OPG	USDC	USH
Accident	14	1	8	1	3						1
Homicide	5		5								
Natural Causes	144	53	15		56	2	1	1	13	3	
Suicide	4		4								
Could Not Be Determined	10		10								
TOTALS	177	54	42	1	59	2	1	1	13	3	1

CHART VIII
DECEDENTS' RACE
FY 2012

RACE	DHS	DAAS	DCFS	DJJS	DSPD	DSPD/ DAAS	DSPD/ DCFS	DSPD/ OPG	OPG	USDC	USH
AMERICAN INDIAN											
Navajo	2		1		1						
Oglala Sioux	1		1								
ASIAN											
Laotian	1	1									
Vietnamese	1	1									
BLACK/AFRICAN AMERICAN	3		3								
CAUCASIAN	151	49	25	1	56	2	1	1	12	3	1
HISPANIC	16	3	10		2				1		
PACIFIC ISLANDER											
Samoan	1		1								
Tongan	1		1								
TOTALS	177	54	42	1	59	2	1	1	13	3	1

CHART IX
FATALITIES BY REGION
FY 2012

DIVISION OF AGING AND ADULT SERVICES

REGION	TOTAL
Eastern	1
Northern	11
Salt Lake	24
Southern	18
TOTAL	54

DIVISION OF CHILD AND FAMILY SERVICES

REGION	TOTAL
Eastern	2
Northern	13
Salt Lake Valley	18
Southwest	5
Western	4
TOTAL	42

DIVISION OF JUVENILE JUSTICE SERVICES

REGION	TOTAL
Region III	1
TOTAL	1

DIVISION OF SERVICES FOR PEOPLE WITH DISABILITIES
COMMUNITY BASED and
UTAH STATE DEVELOPMENTAL CENTER (USDC)

REGION	TOTAL
Central	27
Northern	16
Southern	20
USDC	3
TOTAL	66

OFFICE OF THE PUBLIC GUARDIAN

DIVISION	TOTAL
OPG	13
TOTAL	13

DIVISION OF SUBSTANCE ABUSE/MENTAL HEALTH
UTAH STATE HOSPITAL

REGION	TOTAL
USH	1
TOTAL	1